



Regence
*Life and Health
Insurance Company*

An Independent Licensee of the Blue Cross
and Blue Shield Association

***Short-Term Medical Insurance
for Individuals and Families***

Available in Oregon Only

**FOR YOUR CONVENIENCE, YOU WILL FIND THE APPLICATION
AND RATES AT THE END OF THIS BROCHURE.**

RLH STM OC 04/04

This brochure is designed to give you a very brief description of the important features of the policy. This is not the insurance contract and only the actual policy provisions will govern. Please refer to the policy for a detailed description of the rights and obligations of both you and Regence Life and Health Insurance Company.

This short-term medical policy is non-renewable

**INDIVIDUAL
SHORT-TERM
MEDICAL INSURANCE**

Short-Term Medical Insurance is designed for people who have a temporary need for medical coverage and who are healthy. Short-Term insurance gives you peace of mind by providing coverage for injuries and sudden-onset illnesses.

MEDICAL COVERAGE FOR 30 TO 185 DAYS

Valuable medical protection on a short-term basis for people who are:

- ◆ Between jobs, laid off, or on strike.
- ◆ Waiting to be covered under a group medical plan.
- ◆ Waiting for issuance of an individual contract.
- ◆ Recent graduates.
- ◆ Starting a business.
- ◆ Taking time off from school.
- ◆ In need of temporary medical insurance.

ELIGIBILITY

You are eligible for this policy if you and any family members who apply for coverage:

- ◆ Are under age 65 and will remain under age 65 for the term of the policy. Unmarried dependent children must be under age 23 and dependent upon you for support. Generally, the child must live with you. The exception is when you are legally required to pay for part of the child's support and there is no court order requiring that someone else provide insurance for the child.
- ◆ Are not eligible for Medicare.
- ◆ Are not pregnant. If any member of your family is pregnant, you may not apply for coverage until the pregnancy terminates.
- ◆ Are not covered under any other hospital or medical plan.

TEMPORARY COVERAGE

This short-term medical insurance is designed to provide medical coverage on a temporary basis to fill a temporary need. **It cannot be renewed and is not intended to replace permanent coverage.** However, if the temporary need continues, you may apply for one new policy within a 12-month period.

Important Note: There is **no** continuous coverage between policies. Any condition which may have existed or occurred under one policy will be a pre-existing condition under the subsequent policy, and therefore, will not be covered under the subsequent policy.

CHOICE OF PROVIDERS

You may visit the physician or hospital of your choice. You are not limited to any provider networks or out-of-area service restrictions. No referrals are needed – you have freedom of choice.

SHORT-TERM MAJOR MEDICAL INSURANCE OUTLINE OF COVERAGE

Read the Policy Carefully - This outline of coverage provides a very brief description of the important features of the policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual policy provisions are final and binding. The policy itself sets forth in detail your rights and obligations as well as those of the insurance company. **PLEASE READ THE POLICY CAREFULLY!**

Major Medical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to the deductibles, copayment provisions and other limitations set forth in the policy.

HOW THE POLICY WORKS

You choose the term of coverage - a minimum of 30 days up to the maximum policy term of 185 days. You select the deductible amount - \$250, \$500, \$1,000 or \$2,500 per covered person.

After the deductible is met, the policy pays the rate of payment you have selected - either 80% or 50% of the next \$5,000 - and then 100% of the balance of covered expenses up to a maximum benefit of \$1,000,000 during the policy term.

No family will be required to satisfy more than a total of three times the individual deductible. Covered expenses for all eligible family members may be accrued to satisfy the family deductible.

Important Note: If you become eligible for benefits under any other medical plan during the policy term, your deductible will be equal to the amount of benefits payable for covered expenses under the other plan, if it is greater than the deductible amount you selected.

COVERED EXPENSES

Covered expenses are charges for services or supplies prescribed by a physician for treatment of an illness or injury covered by your policy. The charges must be incurred for medically necessary care while the policy is in effect. A covered expense is incurred on the date a service is rendered or received and may not exceed usual and customary or reasonable as defined in your policy.

Subject to the limitations and conditions described in the policy, the following services and supplies will be considered covered expenses under your policy:

COVERED EXPENSES *(cont.)*

- Hospital room, board, and general nursing care, limited to the hospital's average semi-private room charge, unless confined in a coronary or intensive care unit.
- Other hospital services including emergency room, outpatient and ambulatory surgical center charges.
- Skilled nursing facility room, board, and general nursing care, limited to the facility's average semi-private room charge, up to a maximum of 100 days (other limitations apply; see your policy for complete description of benefit).
- Physician services for diagnosis, treatment, and surgery.
- X-rays, radioactive treatment, and laboratory tests.
- Breast and pelvic exams, mammograms, and Pap smear exams (if such exams are related to an annual women's examination).
- Anesthesia and oxygen and their administration.
- Private nursing care by R.N. or L.P.N. in the home (limitations apply).
- Licensed ambulance service, limited to two trips per illness or injury (other limitations apply; see your policy for complete description of benefit).
- Physical, occupational, speech and audiological therapy, up to 30 sessions (other limitations apply).
- Home health care (up to 40 visits) when prescribed by a physician and rendered by a licensed home health agency (see your policy for complete description of benefit).
- Rental (up to purchase price) of wheel chair, hospital type bed, or other durable medical equipment unique to medical care or treatment.
- Initial placement of a prosthesis required for functional purposes.
- Blood and blood products, administration of blood, and blood processing.
- Drugs which require the written prescription of a physician (limitations apply).
- Non-prescription elemental enteral formula for home use if the formula is medically necessary for the treatment of severe intestinal malabsorption (see your policy for complete description of benefit).
- Organ transplants, including heart, kidney, liver and bone marrow transplants, up to a maximum of \$250,000 (other limitations apply; see your policy for complete description of benefit).
- Kidney disease.
- AIDS, including AIDS, AIDS Related Complex (ARC) or related immuno deficiency disorders.
- Casts, splints, crutches, orthopedic braces, colostomy bags, catheters, syringes, dressings, and initial contact lens following cataract surgery performed while covered under the policy.

EXTENSION OF BENEFITS WHILE HOSPITALIZED

If a covered person is hospital confined on the date your policy ends, coverage for that person **only** will continue without payment of additional premium. The coverage will continue until the person is discharged from the hospital or until the benefit maximum is reached, whichever occurs first.

EXCLUSIONS

Your policy does not cover:

- **Pre-existing conditions** (see the definition in the section titled “Pre-Existing Conditions”).
- Illness or injury incurred in the course of any employment for wage or profit or for which benefits are available under Workers’ Compensation or similar law.
- Illness or injury covered by Medicare.
- Hospital confinement for medical observation or diagnostic exams.
- Eye refractions, routine physical exams, tests or screening procedures (except breast and pelvic exams, mammograms, and Pap smear exams), well baby care, immunizations, hearing aids, eyeglasses, or hearing tests.
- Treatment of drug abuse or drug addiction.
- Organ transplant or complications resulting from or related to an organ transplant, except as specifically provided in your policy.
- Treatment of intentional self-inflicted injury.
- Elective sterilization, family planning, birth control drugs or devices, artificial insemination, in vitro fertilization, diagnosis or treatment of infertility, reversal of sterilization, or genetic testing or counseling.
- Cosmetic surgery (certain exceptions apply).
- Services or supplies not reasonably intended for treatment of illness or injury or which are not medically necessary (as defined in your policy).
- Acupuncture, massage, or massage therapy.
- Private duty nursing for hospital or skilled nursing facility inpatients.
- Mental, emotional or nervous disorders, or counseling of any type, or treatment of learning disorders or disabilities.
- Any condition caused by or arising out of service in the armed forces of any country, or from war or any act of war, or from participation in a felony, riot, or insurrection.
- Sexual dysfunction or inadequacy, or sex change procedures and any resulting complications.
- Services provided by an immediate family member.
- Treatment for obesity or weight control, including surgery and any resulting complications.
- Charges incurred after your policy ends, except as stated in your policy (see section titled “Extension of Benefits While Hospitalized” for brief description).
- Charges which exceed usual and customary or reasonable (as defined in your policy).
- Services rendered by governmental agencies or facilities, except as provided by law.
- Dental exams, treatment, or orthodontics.
- Services or supplies to change the position of the bone of the upper or lower jaw (certain exceptions apply).
- Services or supplies that are experimental or investigational (see your policy for complete details).

EXCLUSIONS *(cont.)*

- Confinement in a health facility for custodial or maintenance care, rest, or to change a patient's environment.
- Pregnancy or childbirth, except complications of pregnancy as stated in your policy.
- Treatment of alcoholism, except as stated in your policy.
- Charges which are reimbursed due to third party liability or motor vehicle coverage (see your policy for complete details).

PRE-EXISTING CONDITIONS

There is no coverage for pre-existing conditions under this policy. Pre-existing condition means an illness or injury for which a covered person received any medical diagnosis, advice, treatment, service, supply, or drug prescription during the 5-year period immediately preceding the effective date of your policy. A condition is also pre-existing if, during the 5-year period immediately preceding the effective date of your policy, symptoms existed which would cause a prudent person to seek diagnosis, advice, care, or treatment.

ACCIDENTAL DEATH BENEFIT

HOW THIS BENEFIT WORKS

We will pay the benefit shown below if all of the following conditions are met:

1. The Covered Person's death results from an Accidental Bodily Injury (as defined in your policy);
2. The Accidental Bodily Injury occurs while insured under the policy; and
3. The death occurs within 365 days after the date of the Accidental Bodily Injury.

Once satisfactory proof of death by Accidental Bodily Injury has been submitted, we will provide the following benefit:

For the Insured (age 18 or older)	\$25,000
For the Covered Spouse	\$25,000
For the Covered Dependent Child (and Insured under age 18)	\$ 5,000

EXCLUSIONS

Your policy does not cover accidental death resulting from injury caused by, or occurring as the result of:

- Suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane;
- Active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- Insurrection, war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- Committing or attempting to commit an assault or felony;
- Any sickness or pregnancy existing at the time of the accident;
- Voluntary use or consumption of any poison, chemical compound or drug, except a prescription drug used or consumed in accordance with the directions of the prescribing physician;
- Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- Diagnostic test, medical or surgical treatment; or
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an injury sustained while insured under this benefit.

HOW TO APPLY

Please refer to the eligibility section of this brochure to be sure you meet the eligibility requirements.

- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- Select the policy term (the number of days this policy will be in effect). The minimum term is 30 days; the maximum term is 185 days.
- Calculate the premium for the policy term, rate of payment, and deductible you select. (Refer to the following rate calculation pages.) If you select a two-party or family policy, the premium rate for the oldest family member will apply. Payment must be made for the full policy term. If the payment received is inadequate, the policy term (the number of days the policy will be in effect) will be shortened.
- Sign the application and the “Authorization For Use And Disclosure Of Protected Health Information” on Page 2 of the application.
- If your application is approved, the policy effective date will be 12:01 a.m. on the **later** of the day **after** the postmark date stamped on the application envelope or the date you request.
- If you answered “Yes” to any of the questions numbered 1 through 4 on the application, **this policy cannot be issued.**
- If you have any questions please call 503-225-6918 or toll-free 1-800-794-5390, ext. 6918.
- Send the application and your check or money order for the full payment amount (made payable to Regence Life and Health Insurance Company) to:

Regence Life and Health Insurance Company
PO Box 1271, MS E-3A
Portland, OR 97207-1271

- Keep this brochure for your records.

REFUNDS

If you are not satisfied with our Short Term Medical Policy, you may return the policy within 10 days of delivery for a full refund of premium. After that time, refunds are not available. Coverage will continue for the full period you selected.

Please note: The application fee of \$20 is non-refundable.

Please read your policy carefully and keep it available for future reference.

Instructions for Calculating Your Policy Premium and Total Payment

1. Determine your premium by choosing from the options below:
 - A. Rate of Payment - - 80/20% or 50/50%
 - B. Deductible - - \$250, \$500, \$1,000 or \$2,500
 - C. Number of Family Members to be Covered – Single, Two-Party, Family
 - D. Age – Age of oldest person to be insured
 - E. Term of Coverage (Number of days of coverage you desire)

Note: You may select from a minimum of 30 days up to a maximum of 185 days.

2. Refer to the following daily rate charts. Find the daily rate for the coverage you desire by using the choices made in options A, B, C and D above.

3. Multiply the daily rate by the Term of Coverage chosen in option E above. This equals your Total Premium.

Example

1. A. Rate of Payment – 80/20%
 B. Deductible - \$250
 C. Number of Family Members to be Covered - Family
 D. Age – 45 years
 E. Term of Coverage – 60 days

2. Daily Rate - \$10.60

3. Term of Coverage 60 days X Daily Rate \$10.60 = \$636.00 Total Premium

Your Rate Calculation

1. A. Rate of Payment – _____ %
 B. Deductible - \$ _____
 C. Number of Family Members to be Covered - _____
 D. Age – _____ years
 E. Term of Coverage – _____ days

2. Daily Rate - \$ _____

3. Term of Coverage _____ X Daily Rate \$ _____ = \$ _____ Premium
 Add \$ 20.00 Application Fee
 \$ _____ Total Payment Due

Daily Rates
Minimum of 30 Days up to a Maximum of 185 Days

Rate of Payment - 80/20%

Rate of Payment - 50/50%

\$250 Deductible

Age	Single	Two-party	Family
Under 20	\$1.80	\$3.60	\$6.10
20 - 24	\$2.00	\$4.00	\$6.60
25 - 29	\$2.20	\$4.40	\$6.90
30 - 34	\$2.40	\$4.80	\$7.40
35 - 39	\$3.10	\$6.20	\$8.80
40 - 44	\$3.30	\$6.60	\$9.10
45 - 49	\$4.00	\$8.00	\$10.60
50 - 54	\$5.20	\$10.40	\$12.90
55 - 59	\$6.70	\$13.40	\$16.00
60 - 64	\$8.90	\$17.80	\$20.40

\$250 Deductible

Single	Two-party	Family
\$1.40	\$2.80	\$4.80
\$1.60	\$3.20	\$5.20
\$1.70	\$3.40	\$5.50
\$1.90	\$3.80	\$5.80
\$2.40	\$4.80	\$6.90
\$2.60	\$5.20	\$7.20
\$3.10	\$6.20	\$8.30
\$4.10	\$8.20	\$10.20
\$5.30	\$10.60	\$12.60
\$7.00	\$14.00	\$16.10

\$500 Deductible

Age	Single	Two-party	Family
Under 20	\$1.40	\$2.80	\$4.60
20 - 24	\$1.60	\$3.20	\$5.00
25 - 29	\$1.80	\$3.60	\$5.40
30 - 34	\$2.00	\$4.00	\$5.90
35 - 39	\$2.30	\$4.60	\$6.50
40 - 44	\$2.70	\$5.40	\$7.30
45 - 49	\$3.30	\$6.60	\$8.50
50 - 54	\$4.30	\$8.60	\$10.50
55 - 59	\$5.80	\$11.60	\$13.40
60 - 64	\$7.00	\$14.00	\$15.90

\$500 Deductible

Single	Two-party	Family
\$1.10	\$2.20	\$3.70
\$1.30	\$2.60	\$4.10
\$1.50	\$3.00	\$4.40
\$1.70	\$3.40	\$4.80
\$1.90	\$3.80	\$5.30
\$2.20	\$4.40	\$5.90
\$2.70	\$5.40	\$6.90
\$3.60	\$7.20	\$8.60
\$4.80	\$9.60	\$11.00
\$5.80	\$11.60	\$13.00

\$1000 Deductible

Age	Single	Two-party	Family
Under 20	\$1.10	\$2.20	\$3.50
20 - 24	\$1.30	\$2.60	\$3.80
25 - 29	\$1.30	\$2.60	\$3.80
30 - 34	\$1.50	\$3.00	\$4.20
35 - 39	\$1.70	\$3.40	\$4.60
40 - 44	\$2.00	\$4.00	\$5.20
45 - 49	\$2.60	\$5.20	\$6.40
50 - 54	\$3.30	\$6.60	\$7.80
55 - 59	\$4.10	\$8.20	\$9.40
60 - 64	\$5.50	\$11.00	\$12.20

\$1000 Deductible

Single	Two-party	Family
\$0.90	\$1.80	\$2.90
\$1.10	\$2.20	\$3.10
\$1.10	\$2.20	\$3.10
\$1.20	\$2.40	\$3.50
\$1.40	\$2.80	\$3.80
\$1.70	\$3.40	\$4.40
\$2.20	\$4.40	\$5.30
\$2.70	\$5.40	\$6.50
\$3.40	\$6.80	\$7.90
\$4.60	\$9.20	\$10.10

\$2500 Deductible

Age	Single	Two-party	Family
Under 20	\$0.90	\$1.80	\$2.70
20 - 24	\$0.90	\$1.80	\$2.70
25 - 29	\$0.90	\$1.80	\$2.70
30 - 34	\$1.00	\$2.00	\$2.90
35 - 39	\$1.30	\$2.60	\$3.30
40 - 44	\$1.60	\$3.20	\$4.10
45 - 49	\$1.90	\$3.80	\$4.60
50 - 54	\$2.50	\$5.00	\$5.80
55 - 59	\$3.20	\$6.40	\$7.20
60 - 64	\$4.00	\$8.00	\$8.90

\$2500 Deductible

Single	Two-party	Family
\$0.70	\$1.40	\$2.10
\$0.70	\$1.40	\$2.20
\$0.80	\$1.60	\$2.20
\$0.80	\$1.60	\$2.40
\$1.00	\$2.00	\$2.80
\$1.30	\$2.60	\$3.40
\$1.50	\$3.00	\$3.80
\$2.00	\$4.00	\$4.80
\$2.60	\$5.20	\$5.90
\$3.30	\$6.60	\$7.30

**APPLICATION FOR INDIVIDUAL
SHORT TERM MEDICAL INSURANCE POLICY
NON-RENEWABLE**

REGENCE LIFE AND HEALTH INSURANCE COMPANY
100 SW Market St.
PO Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 225-6918

NOTE: Coverage begins at 12:01 a.m. on the **later** of the day **after** the postmark date stamped on the application envelope or the date you request. Coverage will take effect only upon receipt of full premium.

MISSING INFORMATION MAY CAUSE YOUR EFFECTIVE DATE TO BE DELAYED.

INSURED'S NAME (PRINT LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER		REQUESTED EFFECTIVE DATE	
STREET ADDRESS				TELEPHONE NUMBER	
CITY, STATE, ZIP CODE				INSURED'S SEX	INSURED'S BIRTHDATE
SPOUSE'S NAME - IF TO BE INSURED		SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S BIRTHDATE	
DEPENDENT CHILDREN MUST BE UNDER 23 YEARS OF AGE AND DEPENDENT ON YOU FOR SUPPORT.					
CHILD'S FULL NAME - IF TO BE INSURED	SEX	BIRTHDATE	FULL NAME	SEX	BIRTHDATE
(1)			(3)		
	SEX	BIRTHDATE		SEX	BIRTHDATE
(2)			(4)		
DEDUCTIBLE AMOUNT/FAMILY DEDUCTIBLE			POLICY TERM (30 – 185 DAYS)		TOTAL PAYMENT
<input type="checkbox"/> \$250/\$750 <input type="checkbox"/> \$500/\$1,500 <input type="checkbox"/> \$1,000/\$3,000 <input type="checkbox"/> \$2,500/\$7,500			NO. OF DAYS _____		
RATE OF PAYMENT AFTER DEDUCTIBLE <input type="checkbox"/> 80% to \$5,000 <input type="checkbox"/> 50% to \$5,000					

1. Are you, or any person to be insured, age 65 or older? YES NO **If YES, this policy cannot be issued.**
2. Are you, or any person to be insured, eligible for Medicare? YES NO **If YES, this policy cannot be issued.**
3. Do you, or any person to be insured, now have any hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy? YES NO **If YES, this policy cannot be issued.**
4. Are you, or any family member, now pregnant? YES NO **If YES, this policy cannot be issued.**

I understand that:

- (1) if my application for coverage is accepted, the Effective Date will be 12:01 a.m. on the later of the day after the postmark date or the requested effective date;
- (2) if my application for coverage is not accepted, any premium I paid will be promptly refunded;
- (3) this is not a continuation of any previous medical plan, including any prior Short Term Medical Plan;
- (4) this policy is not renewable; and
- (5) this insurance will not cover Pre-Existing Conditions. Pre-Existing Conditions are defined as any sickness or injury for which any medical advice, treatment, service, supply or drug prescription has been received, or for which symptoms have been shown, during the 5 years immediately preceding the Effective Date of this coverage.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any incorrect answer may operate to void this coverage.

_____ INSURED'S SIGNATURE	_____ DATE	_____ LICENSED AGENT'S SIGNATURE
_____ PARENT OR GUARDIAN'S SIGNATURE	_____ AGENT NUMBER	_____ LICENSED AGENT NAME (Please print)

*****PLEASE COMPLETE THE AUTHORIZATION ON THE FOLLOWING PAGE *****

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence Life and Health Insurance Company (RLH) or its representatives health information (including alcohol, chemical dependency, mental health treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose to not sign this authorization, RLH may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with RLH.

I may cancel this authorization at any time by sending a written request to RLH. Cancellation of this authorization will not affect any action RLH took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires RLH to tell me that if the party to whom RLH discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

SIGNATURE*: _____ **DATE:** _____

NAME: _____ **(Please print)**

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: _____

Relationship to Insured: Parent Legal Guardian* Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

APPLICANT SPOUSE SIGNATURE: _____ **DATE:** _____

APPLICANT NAME: _____ **(Please print)**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal and Health Information

Regence Life and Health Insurance Company (we, us, our) is committed to protecting the privacy of your personal information. We are required by applicable federal and state laws to maintain the privacy of your personal and health information. This notice explains our privacy practices, our legal duties, and your rights concerning your personal and health information. Personal and health information (referred to in this notice as “personal information”) means any information that is identifiable to you as your personal information, including information regarding your health care and treatment; identifiable factors including your name, age, address, income or other financial information. We will follow the privacy practices that are described in this notice while it is in effect.

Why do we collect your personal information?

We collect personal information from you for a number of reasons, including to help us determine the appropriate products to offer to our members, to pay claims, to provide case management services, and to provide quality improvement services.

How do we collect your personal information?

We collect your personal information through you and your health care providers. For example, we receive personal information from you on your insurance application and from your health care providers through insurance transactions, such as the submission of claims for reimbursement of covered benefits.

How do we protect your personal information?

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices in our employee handbooks as well as disciplinary measures for privacy violations;
- Restricting access to your personal information only to those employees who need to know your personal information in order to provide our services to you, such as paying a claim for a covered benefit;
- Only disclosing your personal information that is necessary for a service company to perform its function on our behalf, and the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.



Regence
Life and Health
Insurance Company

An Independent Licensee of the Blue Cross
and Blue Shield Association

How do we use and disclose your personal information?

We won't disclose your personal information unless we are allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, other than those listed below, require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your personal information, we'll comply with those legal requirements as well. Following are the types of disclosure we may make as allowed or required by law:

- **Treatment:** We may use and disclose your personal information for our treatment activities or for the treatment activities of a health care provider. Treatment activities include disclosing your personal information to a provider in order for that provider to treat you.
- **Payment:** We may use and disclose your personal information for our payment activities, including the payment of claims from physicians, hospitals and other providers for services delivered to you.
- **Health Care Operations:** We may use and disclose your personal information for our internal operations, including our customer service activities.
- **Business Associates:** We may also share your personal information with third party "business associates" who perform certain activities for us. We require these business associates to afford your personal information the same protections afforded by us.
- **Plan Sponsors:** If you are enrolled in a group health plan, we may disclose your personal information to the plan sponsor to permit it to perform administrative activities.
- **Underwriting:** We may receive, use and disclose your personal information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.
- **To You or Your Authorized Representative:** Upon your request, we'll disclose your personal information to you or your authorized representative. If you authorize us to do so, we may use your personal information or disclose it to the person or entity you name on your signed authorization. Once you provide us with an authorization, you may revoke it in writing at any time. Your revocation won't affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request.
- **To Your Parents, if You are a Minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of the state where the treatment is provided, and will make disclosures consistent with such laws.
- **Your Family and Friends:** If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, we may disclose your personal information to a family member or friend to the extent necessary to help with your health care or with payment for your health care. We'll only do so if we determine that the disclosure is in your best interest.

- **Marketing:** We may use your personal information to contact you with information about health-related products and services or about treatment alternatives that may be of interest to you.
- **Research; Death; Organ Donation:** We may use or disclose your personal information for research purposes in limited circumstances. We may disclose the personal information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety:** We may disclose your personal information if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your personal information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law:** We must disclose your personal information when we are required to do so by law.
- **Process and Proceedings:** We may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose limited information to law enforcement officials.
- **Military and National Security:** We may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence, and other national security activities.

What rights do you have as an individual regarding our use and disclosure of your personal information?

You have the right to request all of the following:

- **Access to Your Personal Information:** You have the right to review and receive a copy of your personal information. We may charge you a nominal fee for providing you with copies of your personal information. This right doesn't include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to other state or federal laws that prohibit us to release such information. We may also limit your access to your personal information if we determine that providing the information could possibly harm you or another person. If we limit access based upon the belief that it could harm you or another person, you have the right to request a review of that decision.
- **Amendment:** You have the right to request that we amend your personal information. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for certain reasons, including if you ask us to change information that we didn't create. If we decline your request to amend your records, we'll provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.

- **Accounting of Disclosures:** You have the right to receive a report of instances in which we or our business associates disclosed your personal information for purposes other than for treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosure made prior to April 14, 2003. We'll provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your personal information, a description of the personal information we disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for creating and sending these additional reports.
- **Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your personal information for treatment, payment, health care operations or to persons you identify. We may be unable to agree to your requested restrictions. If we do, we'll abide by our agreement (except in an emergency).
- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your personal information by alternative means or to an alternative location. If you advise us that disclosure of all or any part of your personal information could endanger you, we will comply with any reasonable request provided you specify an alternative means of communication.
- **Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you're also entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Can you "opt out" of certain disclosures?

You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. As a health plan, we must follow many federal and state laws that prohibit us from making these types of disclosures. Because we don't make disclosures that apply to "opt outs," it isn't necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

When is this notice effective?

This notice takes effect April 1, 2003, and will remain in effect until we revise it.

What if this notice of privacy practices changes?

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. For your convenience, a copy of our current notice of privacy practices is always available on our Web site at www.regencelife.com, and you may request a copy at any time by contacting us at the number below.

How can you reach us?

If you want additional information regarding our Privacy Practices, or if you believe we have violated any of your rights listed in this notice, please contact our Customer Service Department toll-free at 1 (800) 794-5390. If you have a complaint, you also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. Your privacy is one of our greatest concerns and there's never any penalty to you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Mailing Instructions

Check one more time before mailing.

Is the application filled in using ink?

Are all questions answered?

Are all boxes checked?

Is it signed and dated?

If requesting monthly bank draft, is a void check included?

Have you included a premium check for the first month's premium made payable to the insurance company?

If not correctly completed, the insurance company will return the application which could delay the start date of coverage.

Please return the application and any attached items to:

Please fill in your e-mail address below and return this form with the application so that we can confirm receipt of your application.